

TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 - 0 1 0

2. STATE:

Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

April 19, 2001

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR, Part 447, Subpart C

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 1,082,580.00  
b. FFY 2002 \$ 5,302,720.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Page 11b  
Attachment 4.19-A, Page 11bb9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

None, New Page

None, New Page

10. SUBJECT OF AMENDMENT:

The Arkansas Title XIX State Plan has been amended to reflect an inpatient rate  
adjustment for private hospitals.

11. GOVERNOR'S REVIEW (Check One):

- ☒
- GOVERNOR'S OFFICE REPORTED NO COMMENT
- 
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- 
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Ray Hanley

14. TITLE:

Director, Division of Medical Services

15. DATE SUBMITTED:

April 19, 2001

16. RETURN TO:

Division of Medical Services  
P. O. Box 1437  
Little Rock, AR 72203-1437Attention: Binnie Alberius  
Slot 1103

## FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

04-25-01

18. DATE APPROVED:

27 APR 2001

19. EFFECTIVE DATE OF APPROVED MATERIAL:

19 APRIL 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

Calvin G. Cline

21. TYPED NAME:

CALVIN G. CLINE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR  
DIV OF MEDICAID & STATE OPERATIONS

23. REMARKS:

CEIAE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT HOSPITAL SERVICES

April 19, 2001

1. Inpatient Hospital Services (Continued)

Private Hospital Inpatient Adjustment

Effective April 19, 2001, all Arkansas private acute care and critical access hospitals (that is, all acute care and critical access hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private pediatric hospitals, shall qualify for a private hospital inpatient rate adjustment. The adjustment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined by Arkansas Medicaid annually, based on available funding. The adjustment shall be calculated as follows:

1. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital adjustment funding pool.
2. For each private hospital eligible for the adjustment, Arkansas shall determine the number of Medicaid discharges for the hospital for the most recent audited fiscal year.

For hospitals who, for the most recently audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine their rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports who were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

3. For each eligible private hospital, Arkansas shall determine its pro rata percentage which shall be a fraction equal to the number of the hospital's Medicaid discharges determined pursuant to step 2 divided by the total number of Medicaid discharges for all eligible hospitals.
4. The amount of each eligible hospital's payment adjustment shall be its pro rata percentage multiplied by the amount of available funding for the private hospital adjustment pool determined pursuant to step 1.

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		DATE EFF	04-19-01
		DATE	AR-01-10

Arkansas shall determine the aggregate amount of Medicaid inpatient reimbursement to private hospitals. Such aggregate amount shall include all private hospital payment adjustments, other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment, but shall not include the amount of the pediatric inpatient payment adjustment. Such aggregate amount shall be compared to the Medicare-related upper payment limit for private hospitals specified in 42 C.F.R. §447.272. Respective Case Mix Indexes (CMI) shall be applied to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related upper payment limit. These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients. To the extent that this private hospital adjustment results in payments in excess of the upper payment limit, such adjustments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.

SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-A  
Page 11bb

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT HOSPITAL SERVICES

April 19, 2001

1. Inpatient Hospital Services (Continued)

Private Hospital Inpatient Adjustment (continued)

5. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.

STATE	Arkansas
DATE REC'D	04-25-01
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SUPERSEDES: NONE - NEW PAGE

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